

Nondiscrimination Testing for Group Health Plans

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The Patient Protection and Affordable Care Act (PPACA) introduced nondiscrimination testing requirements to fully insured group health plans sponsored by U. S. employers. PPACA section 1001(5) added new section 2716 to the Public Health Service Act (PHSA), entitled "Prohibition on discrimination in favor of highly compensated individuals". These rules actually predate PPACA, but previously only applied to self-insured plans. The rules, which do not apply to grandfathered plans, were scheduled to go into effect for policy years beginning on and after September 30, 2010.

Ten days prior to the statutory effective date, the IRS issued Notice 2010-63, requesting public comments on guidance for section 2716. In response to those comments, which generally questioned the public's ability to comply without published regulations, IRS published Notice 2011-1, which has deferred the effective date of 2716 until an unspecified period following the publication of "regulations or other administrative guidance of general applicability has been issued under §2716." In the meantime, IRS is continuing to solicit guidance regarding 2716. Comments should be delivered to no later than March 11, 2011. For more information about the solicitation, see Notice 2011-1.

Now that the pressure is off, you may be tempted to "move on" to more pressing issues. However, this is an opportune time to begin some serious planning for the inevitable. This article addresses the concepts and details of the existing nondiscrimination tests for self-insured plans. If you have a self-insured plan, this is information you need now. If you have an insured plan, having an understanding of these concepts will prepare you to cope with the regulations once issued.

There are three crucial issues facing employers:

- Why should you be concerned?
- What are the rules?
- What should you do?

WHY SHOULD YOU BE CONCERNED?

As stated above, the nondiscrimination rules existed before PPACA, but only applied to self-insured plans. Thus, employers with fully insured plans did not need to comply with those rules and therefore perform the testing. Now PPACA brings insured and self-insured plans into parity, but with one very important difference. If a self-insured plan fails the nondiscrimination tests, the benefits to highly compensated individuals are merely taxable, but if an insured plan fails, the employer has violated the law, and could face sizable penalties.

WHAT ARE THE RULES?

PHSA section 2716 requires that all employer-sponsored insured plans comply with section 105(h)(2) of the Internal Revenue Code. That Code section has two requirements: (1) that the plan “not discriminate in favor of highly compensated individuals as to eligibility to participate”, and (2) that “the benefits provided under the plan do not discriminate in favor of participants who are highly compensated individuals.”

2716 specifies that rules “similar” to those that apply to self-insured plans under IRC section 105(h), paragraphs (3), (4), and (8) apply to insured plans, too. It also refers to the definition of “highly compensated individual” from section 105(h)(5). I’ll summarize the tests that must be passed, then go into each element in detail.

There are four elements to the requirements, two tests and two definitions. The tests are (1) nondiscriminatory eligibility and (2) nondiscriminatory benefits. The definitions are (3) employees and (4) highly compensated individuals. This article draws from IRC section 105(h), paragraphs (2), (3), (4), (8), and Treasury Regulation section 1.105-11.

I’m going to start with the definitions first, because they form the foundation for all of the other rules.

Employees

The Code and Regulation do not explicitly define the term “employee”, but they do clarify which employees are included and which are excluded from the testing. 105(h)(8) includes all employees of the controlled group of corporations, treating them as if employed by a single employer. 105(h)(3) defines categories of employees that may be excluded:

- With less than three years of service
- Under age 25
- Part time or seasonal employees

- Bargaining unit employees
- Non-resident aliens with no US-based earned income

The regulations provide some additional clarification:

- The test for having less than three years of service or being under age 25 is determined prior to the beginning of the plan year. I interpret this to mean that an employee whose third anniversary of employment or 25th birthday is after the first day of the year is excludable.
- Part time means less than 25 hours per week, or less than 35 hours per week if other employees work “substantially” more hours. Note that “substantially” is not defined.
- Seasonal means customary annual employment of less than seven months, or nine months if other employees work “substantially” more months.
- In order to exclude bargaining unit employees, accident and health benefits must have been the subject of good faith bargaining for the current contract period, even if such benefits are not actually provided.

Highly Compensated Individuals

The entire point of this requirement is that these plans not discriminate in favor of highly compensated individuals (HCI), so we need to know who those individuals are. (It's worth noting, however, that if your plans provide perfectly uniform benefits to all employees, and if you can pass the Percentage eligibility test, you do not need to identify your HCIs.)

According to IRC section 105(h)(5)¹, an HCI is an individual that falls into any one of three categories: (A) one of the five highest paid officers, (B) a shareholder with more than 10% of employer stock, or (C) one of the top 25% of employees ranked by pay. The regulations provide some additional clarification:

- Employees that are excludable from the eligibility test due to age, service, etc. (see above) are not counted for the 25% calculation.
- Officer and shareholder status is determined at any point in time during the year in which benefits are provided. That essentially means that there is not a single testing date, so the tests apply throughout the year.
- The 25% of highest paid count is rounded up (e.g., 25% of 10 is 3).

¹ In Notice 2011-1, the IRS requested public comment regarding permission to use the highly compensated employee definition in Code section 414(q) in lieu of this definition.

- Compensation is determined based on the plan year, or alternatively, on the calendar year ending in the plan year.
- Note that 105(h) and the regulation do not define “compensation.” In my opinion, any reasonable definition will be acceptable.
- Retired employees are not considered in the determination of the highest 25% paid employees, even if they continue participation in the plan.

Okay. Now that I’ve defined the terms, let’s get into the tests. There are two: eligibility and benefits.

Eligibility

The purpose of this test is to ensure that the eligibility requirements of the plan do not result in discrimination in favor of HCIs as a class vis-à-vis other employees. There are two alternative tests, the Percentage test and the Classification test; either may be satisfied.

The Percentage test also has two alternatives, either of which may be satisfied. Under the first alternative, the plan should benefit² at least 70% of all employees of the employer (remember the controlled group rule). On the face of it, that seems pretty straightforward. But as they say, the devil is in the details. The regulation does not provide any rounding rule, so I am interpreting “at least” literally. For example, a plan that benefits 70 of 101 employees does not pass that test.

The second alternative Percentage test requires that at least 70% of employees are eligible to participate, and at least 80% of eligible employees actually benefit. For both of the Percentage tests, the employer may ignore excludable employees (see above).

The Classification test allows the employer to define the class of employees that benefit from the plan and submit that classification to the IRS for approval. The IRS will determine if the classification discriminates in favor of HCIs based on the facts and circumstances of the case, applying the Section 410(b)(1)(B) standards applicable to qualified retirement plans.

² What do we mean by “benefit”, and how is that different from being “eligible”? An employee is eligible if he or she is in the eligible class, as defined in the plan or policy provisions. If an eligible employee enrolls in the plan, which includes making required contributions, if any, then he or she is benefitting from the plan, whether or not the employee actually incurs claims under the plan.

Benefits

The last test would seem to be the easiest. The same³ benefits available to HCIs must also be available to other employees. Again, there are details that are clarified in the regulation.

- The test applies to benefit eligibility, not to actual reimbursements
- Benefit limitations, if any, must be uniform for all employees, and not depend on age, years of service, or compensation
- The uniform availability and limitation of benefits applies to dependents and retirees as well as employees. I don't believe that the benefits must be uniform between employees, beneficiaries, and retirees, but they must be uniform within each category between HCI and other. This is an issue I hope for resolution when regulations are published.

Even if the plan does not discriminate in form, it must also avoid discrimination in operation. This is really a facts and circumstances issue. For example, the plan will not be considered discriminatory merely because HCIs are higher utilizers than other employees. However, if the plan, or a benefit in the plan, is terminated, and the termination has the effect of discriminating in favor of HCIs, then prohibited discrimination has occurred, for example, if the termination of a benefit coincides with a period of time during which one or more HCIs utilized that benefit.

Multiple plans

If an employer (or multiple employers in a controlled group) sponsors multiple plans, it may test each plan separately, or designate any combination of plans as a single plan for the purpose of testing eligibility and benefits. I expect the latter to be the more common approach.

³ As evidenced by the requests for comments in Notice 2011-1, it appears that the IRS is looking closely at the concept of nondiscriminatory benefit design from multiple points of view. For example, IRS is requesting comment about (1) measuring on the basis of employer cost rather than the specific benefit design, (2) testing plans in distinct geographic locations separately, and (3) providing safe and unsafe harbor benefit designs. My point here is that once regulations have been finalized, employers may not need to provide identical plan designs to all employees.

Compliance failure and penalties

Earlier in this article, I noted that if an insured plan failed to comply with Section 105(h)(2), the employer could face substantial penalties. You may have wondered if that were correct. Actually, it depends. At this point, it's not clear who will be enforcing the requirements, what the penalties will be, and who will be liable.

PHSA section 2722 describes enforcement of all PHSA individual and group health insurance requirements. In subsection (a), it gives first enforcement priority to the states. If the state does step in and enforce the law, the penalties are not specified by the statute. I presume that each state would set its own enforcement penalties. In the event that a state fails to enforce any provision, the Treasury Secretary is granted authority of enforcement⁴.

If the Secretary enforces the statute, there is a maximum civil penalty of \$100 per day for each individual affected by the failure. The penalty may be reduced based on the facts and circumstances of the case. Section (b)(2)(B) assigns the liability for the penalty to the insurance carrier if the carrier is at fault. If the carrier is not at fault, the liability falls to the group plan, if the plan has two or more sponsors. If there is only one employer sponsoring the plan, then the employer is liable.

At this time, I really don't know if or how the states intend to enforce these requirements, and therefore if the Treasury Department will step in.

⁴ Notice 2011-1 refers to excise taxes under Code chapter 100, civil money penalties under title XXVII of the PHS act, and civil action under Part 5 of ERISA, but makes no mention of state enforcement.

WHAT SHOULD YOU DO?

Now is a good time to begin the testing process. Follow these steps:

- Identify the members of your controlled group of corporations
- Identify the health plans sponsored by those employers, both insured and self-insured
- Assemble a census of the employees of all employers, identifying, for example,
 - Employer
 - Date of birth
 - Date of hire
 - Officer status
 - Shares owned
 - Total compensation
 - Bargaining unit status
 - Health plan eligibility status
 - Health plan participation status
 - Non-resident aliens with no US-based income
- Perform the eligibility testing for each plan, aggregating as necessary to pass the tests. If low enrollments are causing test failure, plan promotion or employee contribution rate adjustment may be needed. Applying for the Classification test is also an option.
- Assemble SPDs for each plan of the controlled group
- If the benefits offered to all employees of the controlled group are not perfectly uniform, it will be necessary to identify highly compensated individuals and determine if any HCI is offered a more valuable benefit than any other employee. In that case, it may become necessary to modify the benefit structures to introduce uniformity, although the anticipated regulations may ultimately provide enough flexibility to avoid that.

This article is not intended to be an exhaustive or authoritative guide to compliance. Employers should consult with their tax, accounting, legal counsel, or other compliance experts before undertaking corrective action to their plans.



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